Clinical Policy: Laronidase (Aldurazyme)

Reference Number: CP.PHAR.152
Effective Date: 02.01.16
Last Review Date: 05.25
Line of Business: Commercial, HIM, Medicaid

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
Laronidase (Aldurazyme®) is a hydrolytic lysosomal glycosaminoglycan-specific enzyme.

FDA Approved Indication(s)
Aldurazyme is indicated for adult and pediatric patients with Hurler and Hurler-Scheie forms of mucopolysaccharidosis I (MPS I) and for patients with the Scheie form of MPS I who have moderate to severe symptoms.

Limitation(s) of use:
- The risks and benefits of treating mildly affected patients with the Scheie form have not been established.
- Aldurazyme has not been evaluated for effects on the central nervous system manifestations of the disorder.

Policy/Criteria
Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that Aldurazyme is **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Mucopolysaccharidosis I: Hurler, Hurler-Scheie, and Scheie Forms (must meet all)**:**

1. Diagnosis of MPS I: confirmed by one of the following (a or b):
   a. Enzyme assay demonstrating deficiency of alpha-L-iduronidase activity;
   b. DNA testing;
2. Member has one of the following (a or b):
   a. Hurler or Hurler-Scheie form of MPS I;
   b. Scheie form of MPS I with moderate to severe symptoms;
3. Age ≥ 6 months;
4. Documentation of member's current weight (in kg);
5. Dose does not exceed 0.58 mg/kg per week (rounded up to the nearest whole vial).

Approval duration:
Medicaid/HIM – 6 months
Commercial – 6 months or to the member's renewal date, whichever is longer

B. Other diagnoses/indications (must meet 1 or 2)**:**
1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

A. Mucopolysaccharidosis I: Hurler, Hurler-Scheie, and Scheie Forms (must meet all)**:**
1. Member meets one of the following (a or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B);*
2. Member is responding positively to therapy as evidenced by improvement in the individual member's MPS I disease manifestation profile *(see Appendix D for examples);*
3. Documentation of member's current weight (in kg);
4. If request is for a dose increase, new dose does not exceed 0.58 mg/kg per week (rounded up to the nearest whole vial).

Approval duration:
Medicaid/HIM – 12 months
Commercial – 6 months or to the member's renewal date, whichever is longer

B. Other diagnoses/indications (must meet 1 or 2)**:**
1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business:

CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or

2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, CP.PMN.53 for Medicaid, or evidence of coverage documents.

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key

6MWT: 6-minute walk test
FDA: Food and Drug Administration
FVC: forced vital capacity
MPS: mucopolysaccharidosis

Appendix B: Therapeutic Alternatives

Not applicable

Appendix C: Contraindications/Boxed Warnings

- Contraindication(s): none reported
- Boxed warning(s): risk of life-threatening hypersensitivity reactions, including anaphylaxis, and acute respiratory complications associated with administration

Appendix D: General Information

- The presenting symptoms and clinical course of MPS I can vary from one individual to another. Some examples, however, of improvement in MPS I disease as a result of Aldurazyme therapy may include improvement in:
  - Percent predicted forced vital capacity (FVC);
  - 6-minute walk test (6MWT);
  - Joint stiffness, Carpal Tunnel Syndrome;
  - Upper airway infection recurrence;
  - Hepatomegaly, splenomegaly;
  - Growth deficiencies.
- In the clinical trials of Aldurazyme in patients ≥ 6 years of age, the mean increase in percent of predicted forced vital capacity (FVC) observed corresponded to a 10% relative improvement over the baseline FVC, which is considered by the American Thoracic Society to be a clinically significant change and not due to week-to-week variability.
- In the clinical trials of Aldurazyme in patients ≥ 6 years of age, patients treated with Aldurazyme demonstrated a 19.7 meter mean increase in the 6MWT after 26 weeks.

V. Dosage and Administration

Indication	Dosing Regimen	Maximum Dose
MPS I	0.58 mg/kg IV once weekly	0.58 mg/kg/week

VI. Product Availability

Vial: 2.9 mg/5 mL

VII. References

1. Aldurazyme Prescribing Information. Cambridge, MA: Genzyme Corporation; December 2023. Available at https://www.aldurazyme.com. Accessed January 8, 2025.
2. Muenzer J. The mucopolysaccharidoses: a heterogeneous group of disorders with variable pediatric presentations. J Pediatr. 2004;144(5 Suppl):S27-S34.
3. Muenzer J, Wraith JE, Clarke LA. Mucopolysaccharidosis I: management and treatment guidelines. Pediatrics. 2009;123:19-29.
4. Stapleton M, Hoshina H, Sawamoto K, et al. Critical review of current MPS guidelines and management. Molecular Genetics and Metabolism. 2019;126:238-45.

Coding Implications

Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
J1931	Injection, laronidase, 0.1 mg

Reviews, Revisions, and Approvals	Date	P&T Approval Date
2Q 2021 annual review: clarified the covered subtypes of MPS I, to align with the FDA-approved indication; revised HIM.PHAR.21 to HIM.PA.154; references reviewed and updated.	02.28.21	05.21
2Q 2022 annual review: no significant changes; added requirement for documentation of member's current weight for dose calculation purposes; references reviewed and updated.	02.26.22	05.22
Template changes applied to other diagnoses/indications and continued therapy section.	09.30.22	
2Q 2023 annual review: no significant changes; references reviewed and updated.	02.09.23	05.23
2Q 2024 annual review: no significant changes; references reviewed and updated.	01.09.24	05.24
2Q 2025 annual review: no significant changes; references reviewed and updated.	03.10.25	05.25

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.